

## REQUEST FOR HEARING/AGENCY ACTION

### NAME OF PROVIDER/PATIENT OR CLIENT/APPLICANT REQUESTING HEARING:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Social Security Number: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Client I.D. or Provider #: \_\_\_\_\_

1. Is the legal authority and jurisdiction under which the agency action requested the Utah Administrative Procedures Act (UAPA)? YES \_\_\_\_ NO \_\_\_\_ (If uncertain leave blank.)

2. The relief or action sought from the agency (the reason you are requesting a hearing) is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The facts and reasons forming the basis for relief or agency are (the reasons you believe you are entitled to a hearing:) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. The names and addresses of all persons to whom you are sending a copy of this request for a hearing:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Please enclose a copy of the denial notice that caused you to request this hearing. THIS IS VERY IMPORTANT. Without this information your hearing could be delayed.

THIS REQUEST MUST BE FILED WITH THE DIRECTOR'S OFFICE/FORMAL HEARINGS, DIVISION OF HEALTH CARE FINANCING WITHIN \_\_\_\_ DAYS OF THE DATE A DENIAL NOTICE ISSUES, (Ninety (90) days for financial eligibility, thirty (30) days for provider requests and anything other than financial eligibility.) A COPY OF THIS REQUEST MUST BE MAILED TO EACH PERSON KNOWN TO HAVE A DIRECT INTEREST IN THE REQUESTED AGENCY ACTION.

If you will be represented by an attorney, the attorney must file a notice of an appearance immediately. If the Division of Health Care Financing does not receive notice at least ten (10) calendar days before any scheduled hearing that an attorney for the petitioner will be present, the hearing may be rescheduled.

Attorney Representation? YES \_\_\_\_ NO \_\_\_\_

NAME OF ATTORNEY/REPRESENTATIVE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

Signature of person requesting hearing

Phone number

Date

Reviewer ID \_\_\_\_\_

SEND REQUEST TO:

**DIVISION OF HEALTH CARE FINANCING  
DIRECTOR'S OFFICE/FORMAL HEARINGS  
PO BOX 143105  
SALT LAKE CITY, UT 84114-3105**